North Texas Nephrology Associates

Follow-Up Questionnaire

Patient Name: _____

Date: _____ Time: _____

This document will become part of your medical record and all questions and answers will remain strictly confidential. Please Read Carefully and Complete ALL THREE Sections.

Section #1 – Background Information

Please fill in the following contact information so that we may better communicate with your other physicians and pharmacists. This helps us to provide better service to you and your other providers.

Primary Care Provider: _____ Office Phone #: _____

Pharmacy: _____ Phone #: _____

We sometimes need to call you to review labs/medications and make other follow-up between visits. Please note your current contact information. Circle the preferred number.

Cell Phone #: _____ Home Phone #: _____

Section #2 – Medications

Please list all ALLERGIES to medications (write NONE if no history of allergic reactions).

Drug	Reaction

Please list all MEDICATIONS that you are currently taking. Include all of your prescription medicines, over-the-counter medicines, inhalers, herbal medicines, vitamins, and injections. Please indicate if a medication is new (or with a changed dose), if known.

New	Medication	Dose	Times Per Day
❑			
❑			
❑			
❑			
❑			
❑			
❑			
❑			
❑			
❑			
❑			
❑			
❑			
❑			
❑			
❑			
❑			
❑			

Section #3 – Review of Symptoms

Please review the following symptoms and check the appropriate boxes for any current problems. At the bottom, note any other significant symptoms not on this list.

General, Constitutional

Good general health ..... ❑ no ❑ yes
Weight change ..... ❑ no ❑ yes
Fevers, chills, or sweats ..... ❑ no ❑ yes
Fatigue ..... ❑ no ❑ yes

Eyes and Vision

Change in vision ..... ❑ no ❑ yes
Wear glasses or contact lenses ..... ❑ no ❑ yes

Ears, Nose, Throat

Hearing troubles ..... ❑ no ❑ yes
Ringing in the ears ..... ❑ no ❑ yes
Sinus problems ..... ❑ no ❑ yes
Nose bleeds ..... ❑ no ❑ yes
Sore throat ..... ❑ no ❑ yes
Bad breath or taste ..... ❑ no ❑ yes

Heart and Cardiovascular

Chest pain ..... ❑ no ❑ yes
Palpitations or heart racing ..... ❑ no ❑ yes
Leg pain with exercise ..... ❑ no ❑ yes
Swelling of feet, ankles, hands ..... ❑ no ❑ yes

Respiratory

Shortness of breath ..... ❑ no ❑ yes
Frequent coughing ..... ❑ no ❑ yes
Coughing up blood ..... ❑ no ❑ yes
Wheezing ..... ❑ no ❑ yes

Gastrointestinal

Loss of appetite ..... ❑ no ❑ yes
Abdominal pain ..... ❑ no ❑ yes
Nausea and/or vomiting ..... ❑ no ❑ yes
Diarrhea ..... ❑ no ❑ yes
Constipation ..... ❑ no ❑ yes
Blood in stools ..... ❑ no ❑ yes
Black/tarry stools ..... ❑ no ❑ yes

Other Complaints or Issues:

Genitourinary

Burning or painful urination ..... ❑ no ❑ yes
Frequent urination ..... ❑ no ❑ yes
Blood in urine ..... ❑ no ❑ yes
Incontinence or dribbling ..... ❑ no ❑ yes

Musculoskeletal

Joint pain ..... ❑ no ❑ yes
Joint stiffness or swelling ..... ❑ no ❑ yes
Back pain ..... ❑ no ❑ yes
Cold extremities ..... ❑ no ❑ yes

Skin

Rash or itching ..... ❑ no ❑ yes
Change in skin color ..... ❑ no ❑ yes
Change in hair or nails ..... ❑ no ❑ yes

Neurological

Frequent headaches ..... ❑ no ❑ yes
Light-headed or dizzy ..... ❑ no ❑ yes
Seizures ..... ❑ no ❑ yes
Numbness or tingling ..... ❑ no ❑ yes
Stroke ..... ❑ no ❑ yes

Psychiatric

Memory loss or confusion ..... ❑ no ❑ yes
Nervousness or anxiety ..... ❑ no ❑ yes
Depression ..... ❑ no ❑ yes
Sleep problems ..... ❑ no ❑ yes

Endocrine

Heat or cold intolerance ..... ❑ no ❑ yes
Excessive thirst or urination ..... ❑ no ❑ yes

Hematologic / Lymphatic

Slow to heal after cuts ..... ❑ no ❑ yes
Easily bruise or bleed ..... ❑ no ❑ yes
Transfusion ..... ❑ no ❑ yes

Physician Review

The information above has been recorded by the patient/family +/- the assistance of office staff. I have thoroughly reviewed all information with further questioning and clarification as necessary.

Physician Signature _____ Date _____ Time _____